FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 N County Farm Rd PO Box 708 (Number) Wheaton (City) 60187 (Zip Code)

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 784-4212

IDPA ID Number: 36-6006551-002

Date of Initial License for Current Owners: Prior to 1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics, Sr. Consultant **Telephone Number:** (847) 259-7373, Ext.111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Dec. 1, 2004 to Nov. 30, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3/24/2006 (Date)
(Type or Print Name) Beth Welch
(Title) Administrator

Paid Preparer

(Signed) 3/24/2006 (Date)
(Print Name and Title) Patrick Szajkovics, Senior Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 3315 W.Algonquin Rd.S-110,Rolling Meadows,IL 60008
(Telephone) (847) 259-7373 Fax # (847) 259-9869

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	508	Skilled (SNF)	508	185,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	508	TOTALS	508	185,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	95,049	16,842	11,340	123,231	8
9	SNF/PED					9
10	ICF	1,460	0	0	1,460	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	96,509	16,842	11,340	124,691	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.25%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Empl. Meals, Empl. Pharmacy & Therapy, County Laundry & Pharmacy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started Pre - 1/1/1935

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 9,404

Medicare Intermediary Mutual of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: YE 11/30/05 Fiscal Year: YE 11/30/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,615,007	153,385	8,828	1,777,220		1,777,220	(516,179)	1,261,041			1
2	Food Purchase		1,027,730		1,027,730		1,027,730	(298,496)	729,234			2
3	Housekeeping	1,469,337	146,685	53,590	1,669,612		1,669,612	(99,527)	1,570,085			3
4	Laundry	293,526	110,792	4,537	408,855		408,855	(907)	407,948			4
5	Heat and Other Utilities			1,542,709	1,542,709		1,542,709		1,542,709			5
6	Maintenance			880,127	880,127		880,127	(105,785)	774,342			6
7	Other (specify):*											7
8	**TOTAL General Services**	3,377,870	1,438,592	2,489,791	7,306,253		7,306,253	(1,020,894)	6,285,359			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,292,614	582,366	1,111,228	12,986,208	(163,185)	12,823,023	(782,317)	12,040,706			10
10a	Therapy	574,002	24,725	9,247	607,974	(9,919)	598,055	837,670	1,435,725			10a
11	Activities	444,341	22,478	274	467,093		467,093		467,093			11
12	Social Services	375,016	2,348	1,507	378,871		378,871		378,871			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	12,685,973	631,917	1,122,256	14,440,146	(173,104)	14,267,042	55,353	14,322,395			16
	C. General Administration											
17	Administrative	147,765		560,921	708,686		708,686	23,827	732,513			17
18	Directors Fees											18
19	Professional Services			98,914	98,914		98,914		98,914			19
20	Dues, Fees, Subscriptions & Promotions			140,052	140,052		140,052	(100,011)	40,041			20
21	Clerical & General Office Expenses	1,128,853	76,048	86,904	1,291,805		1,291,805	(11,571)	1,280,234			21
22	Employee Benefits & Payroll Taxes			5,478,951	5,478,951		5,478,951	73,513	5,552,464			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,843	25,843		25,843		25,843			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			383,204	383,204		383,204		383,204			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,276,618	76,048	6,774,789	8,127,455		8,127,455	(14,242)	8,113,213			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,340,461	2,146,557	10,386,836	29,873,854	(173,104)	29,700,750	(979,783)	28,720,967			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Du Page Convalescent Center #0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,324,336	1,324,336		1,324,336	9	1,324,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			226,674	226,674		226,674		226,674			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,551,010	1,551,010		1,551,010	9	1,551,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	420,896	2,714,922	24,226	3,160,044	173,104	3,333,148		3,333,148			39
40	Barber and Beauty Shops	78,752			78,752		78,752		78,752			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,130	278,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	499,648	2,714,922	24,226	3,238,796	173,104	3,411,900	278,130	3,690,030			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,840,109	4,861,479	11,962,072	34,663,660		34,663,660	(701,644)	33,962,016			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(110,611)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(907)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,293)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,811)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,811)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		163,185	10	44
45	Other-Attach Schedule Exc Thrpy	X		9,919	10a	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 173,104		47

STATE OF ILLINOIS

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2004

Ending: Nov. 30, 2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	$ (97,791)	1	1
2	Cafeteria Income - Food	(56,550)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(418,388)	1	3
4	421 Cafeteria Income - Food	(241,946)	2	4
5	Other Misc Revenues	(5,278)	21	5
6	Overpayments and Refunds expense	(100,011)	20	6
7	West Campus Cleaning Revenue	(99,527)	3	7
8	Provider Participation Fee	278,130	42	8
9	Indirect IMRF cost adjustment	38,053	22	9
10	Indirect FICA cost adjustment	35,460	22	10
11	County Board Expense	23,827	17	11
12	County Furn, Equipnemt Small Value	4,826	6	12
13	Loss on Disposal of Moveable Equipment	9	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(639,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(516,179)	0	0	0	0	0	0	0	0	0	0	(516,179)	1
2	Food Purchase	(298,496)	0	0	0	0	0	0	0	0	0	0	(298,496)	2
3	Housekeeping	(99,527)	0	0	0	0	0	0	0	0	0	0	(99,527)	3
4	Laundry	(907)	0	0	0	0	0	0	0	0	0	0	(907)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(105,785)	0	0	0	0	0	0	0	0	0	0	(105,785)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,020,894)	0	0	0	0	0	0	0	0	0	0	(1,020,894)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(782,317)	0	0	0	0	0	0	0	0	0	(782,317)	10
10a	Therapy	0	837,670	0	0	0	0	0	0	0	0	0	837,670	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	55,353	0	0	0	0	0	0	0	0	0	55,353	16
	C. General Administration													
17	Administrative	23,827	0	0	0	0	0	0	0	0	0	0	23,827	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(100,011)	0	0	0	0	0	0	0	0	0	0	(100,011)	20
21	Clerical & General Office Expenses	(11,571)	0	0	0	0	0	0	0	0	0	0	(11,571)	21
22	Employee Benefits & Payroll Taxes	73,513	0	0	0	0	0	0	0	0	0	0	73,513	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,242)	0	0	0	0	0	0	0	0	0	0	(14,242)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,035,136)	55,353	0	0	0	0	0	0	0	0	0	(979,783)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	9	0	0	0	0	0	0	0	0	0	0	9	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9	0	0	0	0	0	0	0	0	0	0	9	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,130	0	0	0	0	0	0	0	0	0	0	278,130	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	278,130	0	0	0	0	0	0	0	0	0	0	278,130	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(756,997)	55,353	0	0	0	0	0	0	0	0	0	(701,644)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing	$ 782,317	Marianjoy Rehablink Corp - Joint Venture	50.00%	$	$ (782,317)	1
2	V	10a	Physical Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	335,889	335,889	2
3	V	10a	Speech Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	380,543	380,543	3
4	V	10a	Occup Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	121,238	121,238	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 782,317			$ 837,670	$ * 55,353	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: v. 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Du Page County Government
Street Address: 421 N. County Farm Road (Finance Dept)
City / State / Zip Code: Wheaton, Illinois 60187
Phone Number: (630) 407-6121 (Lynn Wood)
Fax Number: (630) 407-6102

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F. & Social Security	Direct Cost	22,704,095		$ 22,704,095	$ 0	2,943,889	$ 2,943,889	1
2	6	Furn/Equip Small Value	Direct Cost	15,965		15,965	0	4,826	4,826	2
3	19	Finance & AP	# of A/P Claims	429,578	173	429,578	244,347	34,563	34,563	3
4	19	County Audit & Auditor	% & # of A/P Claims	300,618	170	300,618	38,438	13,458	13,458	4
5	19	General Acctg & Budget	% of All Depts	1,724,978	51	1,724,978	1,005,888	33,823	33,823	5
6	21	Mail Delivery	Wtd Avg # of Del	300,000	44	300,000	164,392	6,055	6,055	6
7	22	Workers Comp Claims	Direct Cost	1,073,254	173	1,073,254	0	240,370	240,370	7
8	22	Worker Comp Premiums	# of Claims & FTEs	131,871	173	131,871	0	22,625	22,625	8
9	26	Property Insurance	Building Value %	311,281	40	311,281	0	27,776	27,776	9
10	26	Gen/Prof Liability Insurance	Direct Cost	239,124	11	239,124	0	41,838	41,838	10
11	26	Gen & Excess Liab	FTEs/Direct Cost/#	961,702	2444	961,702	0	277,551	277,551	11
12	26	Surety Bond & Premiums	Direct Cost/FTE	24,117	2444	24,117	0	7,407	7,407	12
13	22	Unemployment Comp Ins	Direct Cost/FTE	176,980	2444	176,980	0	46,656	46,656	13
14	26	Service retention Fee	# of Ins Claims	111,925	14	111,925	0	28,632	28,632	14
15	5	Utilities	Square Footage	2,614,318	43	2,614,318	0	165,270	165,270	15
16	5	Space & HVAC	Square Footage	6,680,379	44	6,680,379	2,835,623	819,230	819,230	16
17	17	Security	Square Footage	1,004,983	60	1,004,983	601,615	175,078	175,078	17
18	6	Building Maintenance	Direct Cost	2,455,206	44	2,455,206	1,042,162	879,744	879,744	18
19	35	Rental of Equipment	Direct Cost	10,526	44	10,526	0	958	958	19
20	6	Repair & Maint of Equip	Direct Cost	78,609	44	78,609	0	6,233	6,233	20
21	17	Personnel Costs	% of Ads & FTEs	1,659,170	45	1,659,170	850,539	336,266	336,266	21
22	17	Purchasing Costs	# of Purchase Orders	671,216	91	671,216	379,810	49,577	49,577	22
23	17	County Board	Comm Assignmnts	897,994	47	897,994	897,994	23,827	23,827	23
24										24
25	TOTALS					$ 44,577,889	$ 8,060,808		$ 6,185,652	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Reinf Cncrt Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Bldgs	400,000	1947	$ 784,360	1
2					2
3	TOTALS	400,000		$ 784,360	3

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1947	$ 70,858	$	30	$	$	$ 70,858	4
5				1983	1,172,064	34472	34	34,472		778,504	5
6	104			1978	4,456,548	148551	30	148,551		4,097,548	6
7	16			1979	1,750,524	58351	30	58,351		1,526,847	7
8	100			1993	6,516,821	238418	Various	238,418		3,101,381	8
	Improvement Type**										
9	Mech room renovation & heat exchangers			1976	44,372		20			44,372	9
10	Alarm equip doors & other, Project 181			1977	8,545		20			8,545	10
11	Cyclone dust collector			1978	12,188		20			12,188	11
12	Flagpole			1979	844		20			844	12
13	Kitchen floor / Ground north remodel			1981	212,304		20			212,304	13
14	South Bldg renovation - Phase III (Per 1989 Adj)			1983	3,871,516		20			3,871,516	14
15	South Bldg renovation - Phase III Architect fees			1983	262,953		20			262,953	15
16	Laundry, 3-Center & Nurse station remodel			1985	261,742	9,945	15/20	9,945		261,742	16
17	Tubs & Parking lot projects			1989	199,883	9,994	20	9,994		159,076	17
18	Oxygen Manifold - North Bldg			1990	5,423	271	20	271		4,045	18
19	Ground North & Hydrotherapy remodel			1991	331,512	18,438	15/20/25	18,438		256,598	19
20	Window replacement, 3-Center & Nurse station remodel			1992	604,207	32,536	10/15/20/25	32,536		448,956	20
21	Laundry water heater & softners, asphalt rep & landscape			1993	588,826	30,800	10/12/15/20	30,800		411,254	21
22	ADA & Elevator upgrades, Nurse station remodel & misc			1994	105,577	4,131	5/10/15/20	4,131		74,943	22
23	Sewer Ejector pumps & Carpet replacement			1995	31,457	694	5/10	694		31,457	23
24	Carpet replace in Recreation & Volunteer areas & misc			1996	7,963		5			7,963	24
25	Chilled water bridges, Liquid oxygen, Lights refit & Elevator			1997	320,587	18,808	5/10/20	18,808		158,793	25
26	Elevator Pit ladders & automatic entrance doors			1998	10,922	950	10/20	950		6,903	26
27	Lobby remodel, Carpet, Elevator safety system & HVAC			1999	701,043	56,998	5/10/20	56,998		441,656	27
28	Tubs, Reception, Laundry, Kitchen Elev, HVAC & access eqp			2000	848,131	77,604	5/10/15/20	77,604		450,468	28
29	Tub room remodel, Life safety system, Elev & Liq Oxygen eqp			2001	473,208	47,321	10	47,321		190,442	29
30	Carpeting, incl North Day Room			2002	8,582	1,717	5	1,717		5,942	30
31	Roof rehab, Card readers & Kitchen renovation			2002	219,254	21,925	10	21,925		69,536	31
32	Fire Alarm Dampers, Fire System & Constructn Admin			2002	1,515,449	151,545	10	151,545		454,671	32
33	Director Signage			2002	65,448	3,273	20	3,273		10,090	33
34	HVAC Modifications			2002	102,341	6,823	15	6,823		20,468	34
35	Curtain Wall Installation			2003	13,140	876	15	876		2,117	35
36	Carpet Installation			2003	1,148	230	5	230		651	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fencing - Wrought Iron	2003	$ 21,810	$ 873	25	$ 873	$	$ 2,472	37
38	Curtain Wall Project	2003	338,936	33,894	10	33,894		70,612	38
39	Alarm System Prof Fees	2003	1,000	200	5	200		417	39
40	Fire Alarm System Replacement	2004	165,176	16,518	10	16,518		26,153	40
41	Hi-Res LW Light Camera	2004	2,768	554	5	554		646	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733	347	5	347		578	42
43	Pharmacy Storage Remodeling	2004	2,050	205	10	205		342	43
44	Reconfigure Front	2005	6,599	605	10	605		605	44
45	Commercial Carpet	2005	4,357	399	10	399		399	45
46	Air Handler CC	2005	75,447	4,401	10	4,401		4,401	46
47	New Door	2005	3,295	330	5	330		330	47
48	Wireless Exterior Gate	2005	12,010	801	5	801		801	48
49	Roof Top HVAC in Residents Dining Rm	2005	7,235	121	10	121		121	49
50	Floor Preparation	2005	721	54	10	54		54	50
51	North Entrance Badge Reader	2005	1,712	228	5	228		228	51
52	Wanderer System	2005	2,970	248	5	248		248	52
53	Relocate Card Reader - Door 4, Ground Floor	2005	2,704	135	5	135		135	53
54	Asst Administrators Office Carpet	2005	1,068	53	5	53		53	54
55	Fiber /PBX FON System	2005	2,842		5				55
56	Alarm Installation	2005	2,475		10				56
57	Door Repairs - 2 items	2005	8,463		5				57
58	Patch & Repair	2005	2,902		5				58
59	Fire Pump and Installation	2005	58,432		10				59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 25,522,085	$ 1,034,637		$ 1,034,637	$	$ 17,564,226	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,980,376	$ 265,162	$ 265,162	$	3/5/10	$ 2,159,772	71
72	Current Year Purchases	133,155	18,947	18,947		5	18,947	72
73	Fully Depreciated Assets	1,552,665					1,552,665	73
74	Deletions	(13,531)	14	23	9	3/10	(13,522)	74
75	TOTALS	$ 4,652,665	$ 284,123	$ 284,132	$ 9		$ 3,717,862	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint/02 Van	Various/97 White Ford Van	Various/02	$ 182,531	$ 1,169	$ 1,169	$	3/4/10	$ 181,654	76
77	Grounds Maintenance	John Deere Tractor	1999	12,685	1,269	1,269		10	8,563	77
78	Maint & Transport	Ford A-10 Van	2000	38,971				4	38,971	78
79	Maint & Transport	Window Van - 2001	2001	31,396	3,138	3,138		10	12,558	79
80	TOTALS			$ 265,583	$ 5,576	$ 5,576	$		$ 241,746	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 31,224,693	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,324,336	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,324,345	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 21,523,834	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Miscellaneous	$ 1,965,851	92
93			93
94			94
95		$ 1,965,851	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 226,674 Description: Facility Medical and Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Training not necessary since hired aides already have training.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	4216	hrs	147,270				4,216	147,270	4
5	Physician Care	Ln 10, Col 8		visits		4,360	30,000		4,360	30,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	75457	# of prescrpts	420,896			2,507,567	75,457	2,928,463	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program	Ln 39, Col 8			107,542			65,562		173,104	12
13	Other (specify):										13
14	TOTAL				$ 675,708	4,360	$ 30,000	$ 2,573,129	84,033	$ 3,278,837	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 666,615	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	5,122,850		3
4	Supply Inventory (priced at Cost)	369,882		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,159,347	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	25,522,084		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,600,933		16
17	Accumulated Depreciation (book methods)	(21,523,832)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	1,965,851		22
23	Other(specify): Leased Equip	317,315		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,666,711	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,826,058	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,126,622	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,352,279		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued Liabilities	312,272		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,791,173	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Compensation	791,404		43
44	Lease Purchase	102,633		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 894,037	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,685,210	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,140,848	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,826,058	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,787,951	1
2	Restatements (describe):		2
3	Audit adj 6 to PY Retained Earnings	486	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,788,437	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,860,699)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (7,860,699)	17
	B. Transfers (Itemize):		
18	Contributed Capital	3,213,110	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 3,213,110	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 14,140,848	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 25,764,377	1
2	Discounts and Allowances for all Levels	(8,874,078)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,890,299	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,000,097	6
7	Oxygen	86,619	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,086,716	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,000,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,961	13
14	Non-Patient Meals	882,217	14
15	Telephone, Television and Radio	110,611	15
16	Rental of Facility Space		16
17	Sale of Drugs	3,622,561	17
18	Sale of Supplies to Non-Patients	5,278	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	907	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,648,535	23
	D. Non-Operating Revenue		
24	Contributions	32,510	24
25	Interest and Other Investment Income***	45,383	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77,893	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	West Campus Cleaning Revenue	99,527	28
28a	Misc. Other Losses	(9)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 99,518	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 26,802,961	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,306,253	31
32	Health Care	14,440,146	32
33	General Administration	8,127,455	33
	B. Capital Expense		
34	Ownership	1,551,010	34
	C. Ancillary Expense		
35	Special Cost Centers	3,238,796	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 34,663,660	40
41	**Income before Income Taxes (line 30 minus line 40)****	(7,860,699)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (7,860,699)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,794	2,111	$ 107,644	$ 50.99	1
2	Assistant Director of Nursing	3,527	4,235	157,899	37.28	2
3	Registered Nurses	124,779	143,392	4,109,572	28.66	3
4	Licensed Practical Nurses	37,120	42,083	974,174	23.15	4
5	CNAs & Orderlies	355,126	407,169	5,685,028	13.96	5
6	CNA Trainees					6
7	Licensed Therapist	16,593	18,878	568,165	30.10	7
8	Rehab/Therapy Aides	20,621	24,176	349,861	14.47	8
9	Activity Director	1,755	2,073	54,520	26.30	9
10	Activity Assistants	22,356	26,090	389,820	14.94	10
11	Social Service Workers	15,584	18,343	375,016	20.44	11
12	Dietician	7,303	8,526	164,191	19.26	12
13	Food Service Supervisor	3,946	4,462	131,845	29.55	13
14	Head Cook	1,996	2,252	38,598	17.14	14
15	Cook Helpers/Assistants	58,777	65,420	751,590	11.49	15
16	Dishwashers	54,512	58,089	528,784	9.10	16
17	Maintenance Workers					17
18	Housekeepers	115,221	127,978	1,469,338	11.48	18
19	Laundry	23,975	27,271	293,526	10.76	19
20	Administrator	1,774	2,109	128,431	60.90	20
21	Assistant Administrator	498	544	19,334	35.54	21
22	Other Administrative	13,416	15,207	362,005	23.81	22
23	Office Manager					23
24	Clerical	38,075	43,256	766,849	17.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,847	2,111	76,871	36.41	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,445	6,415	107,601	16.77	31
32	Other Health Ca Nrs Sect, WC	8,532	9,651	150,695	15.61	32
33	Other(specify) Barber/Beauty	4,593	5,430	78,752	14.50	33
34	TOTAL (lines 1 - 33)	939,165	1,067,271	$ 17,840,109 *	$ 16.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	17	$ 581	Ln 1, C 3	35
36	Medical Director				36
37	Medical Records Consultant	93	2,778	Ln 10, C 3	37
38	Nurse Consultant	198	9,875	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6,268	185,294	Ln 10a,C 8	40
41	Occupational Therapy Consultant	7,349	209,928	Ln 10a,C 8	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,929	66,882	Ln 10a,C 8	43
44	Activity Consultant	4	224	Ln 11, C 3	44
45	Social Service Consultant	59	3,111	Ln 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	15,917	$ 478,673		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,988	$ 149,566	Ln 10, C 3	50
51	Licensed Practical Nurses	7	300	Ln 10, C 3	51
52	Certified Nurse Assistants/Aides	362	10,724	Ln 10, C 3	52
53	TOTAL (lines 50 - 52)	3,357	$ 160,590		53

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Welch	Administrator	None	$ 128,431
Barbara Hyde	Asst. Administrator	None	19,334
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,765

B. Administrative - Other

Description	Amount
Other Contractual Costs (From County) for	$
Security, Personnel, Purchasing & County Board	584,748
[Detail on Schedule VIII]	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 584,748
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
County Finance & A/P	Finance & AP	$ 34,563
County Audit & Auditor	Financial Audit	13,458
County Acctg & Budget	Accounting	33,823
Other Misc	Cost Reprt & Acctg Srvcs	17,070
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 98,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,625
Unemployment Compensation Insurance	46,656
FICA Taxes	1,291,583
Employee Health Insurance	2,295,583
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,652,306
Workers Comp Claims	240,370
Accrued Comp - Retention Expense	3,341
TOTAL (agree to Schedule V, line 22, col.8)	$ 5,552,464

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	
(Indicate # of checks performed N/A)	3,000
Life Srvcs Network	18,526
Illinois Dept of Revenue	6,180
County Nrsg Home Assoc. of IL	3,520
DuPage County Health Dept	2,030
American Dietetic Association	858
Various Other Amounts-per sch	3,937
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,041

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	2,127
Seminar Expense	23,716
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,843

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2004 Ending: Nov. 30, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2004 **Ending:** Nov. 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **County Nrsg Home Assoc. of IL, $3520**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **145,592** Line **10, Col 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **278,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **814,675**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Wolf & Company, CPA's** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Final Audit not yet available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.